



**COUNTY OF LOS ANGELES
DEPARTMENT OF HEALTH SERVICES
Public Health**

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May 16, 2005

Dear Prospective Applicant:

**REQUEST FOR INFORMATION (RFI #2005-01) FOR PROVISION OF RESIDENTIAL
HOSPICE AND SKILLED NURSING SERVICES LEVEL A OR LEVEL B FOR PEOPLE
LIVING WITH HIV/AIDS IN LOS ANGELES COUNTY**

The Office of AIDS Programs and Policy (OAPP) from the Los Angeles County Department of Health Services is soliciting information from potentially qualified providers of Residential Hospice and Skilled Nursing Services for people living with HIV/AIDS (PLWH/A) in Los Angeles County.

As a part of the HIV/AIDS Continuum of Care endorsed by the Commission on HIV/AIDS Health Services (CHHS), OAPP and the Department of Health Services, residential services are considered vital to supporting PLWH/A and their families in accessing medical care in order to mitigate disease progression and further infection, and maintain compliance with standards of care for people with HIV disease. Skilled nursing services are necessary for those clients who require skilled nursing care, but not in a hospital setting. Residential hospice services are for those clients who have received a terminal diagnosis as a result of their HIV infection, and need assistance in managing end-stage HIV/AIDS symptoms and planning for the end of life. Funding for these services is available through Ryan White CARE Act Title I funds, and Net County Cost funds.

Agencies with proper licensure and history of providing these services, especially to clients with HIV/AIDS, are encouraged to complete and return the enclosed survey. Information from the survey may be used to assist in the development of an upcoming Request for Proposals (RFP) for these services.

Background information is included in this packet. Agencies who submit completed surveys will be notified of the upcoming RFP and invited to apply for funds. However, agencies that do not complete and return the survey are not precluded from applying for funds when the RFP is released.

REQUEST FOR INFORMATION (RFI) FOR PROVISION OF RESIDENTIAL HOSPICE AND
SKILLED NURSING SERVICES LEVEL A OR LEVEL B FOR PEOPLE LIVING WITH HIV/AIDS
IN LOS ANGELES COUNTY

May 16, 2005

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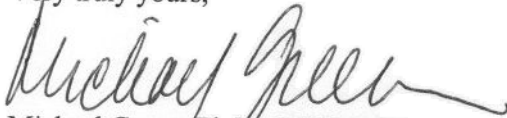
Please complete the survey by May 26, 2005. You can fax it, mail it in the enclosed envelope, or request an electronic version by contacting Susan Carlon at scarlon@ladhs.org. You can also download the survey from the OAPP website at www.lapublichealth.org/aids/rfp.htm or <http://camisvr.co.la.ca.us/lacobids/> (Search by Department under "Health Services" for OAPP RFI# 2005-01).

If you have questions regarding the survey or any of the background information contained within this packet, please forward questions or requests for more information in writing to:

Susan Carlon, Solicitations Coordinator
Office of AIDS Programs and Policy
Division of Planning and Research
600 S. Commonwealth Avenue, Suite 200
Los Angeles, CA 90005
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Thank you very much for your interest.

Very truly yours,



Michael Green, Ph.D., MHSA, Director
Division of Planning and Research

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Enclosures

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REQUEST FOR INFORMATION (RFI #2005-01) FOR PROVISION OF
RESIDENTIAL HOSPICE AND SKILLED NURSING SERVICES
LEVEL A OR LEVEL B FOR PEOPLE LIVING WITH HIV/AIDS
IN LOS ANGELES COUNTY

The Los Angeles County (County) Office of AIDS Programs and Policy (OAPP) is preparing a Request for Proposals (RFP) for the development and implementation of Residential Hospice and Skilled Nursing Facility Services Levels A or Level B. The goal of Residential Hospice and Skilled Nursing Facility Services Level A or Level B is to serve as an integral component of Los Angeles County's Removal of Barriers to HIV/AIDS care by augmenting and supplementing Los Angeles County's existing services for HIV-positive clients who require residential services.

This is accomplished by offering people living with HIV/AIDS (PLWH/A), depending on their housing needs, with an array of Residential Service modalities.

PURPOSE

The RFI is designed to:

1. Provide prospective respondents with general information regarding the objectives and expected outcomes of the services to be solicited
2. Gather information useful to the development of a future RFP
3. Gather preliminary, non-binding cost estimates

GENERAL INFORMATION

OAPP does not anticipate that any contract(s) will be awarded as a result of this RFI; rather, it is expected that respondents to this RFI will be placed on a list of potential RFP respondents and shall receive an announcement of a formal RFP to be issued in the future.

However, in the event that OAPP, in its sole discretion, determines that insufficient responses to this RFI have been submitted, please be notified that the County reserves the right to enter into sole source negotiations in lieu of any subsequent RFP.

The RFP process will be open to all respondents regardless of their decision to participate in this RFI process. Responding to this RFI is not required in order to respond to the upcoming RFP. Responding to this RFI does not confer any special privileges to those who later respond to the RFP.

Responses provided are non-binding. The County shall neither be obligated in any way to make an award as a result of this RFI, nor issue a subsequent RFP. In no event shall

the County be responsible for the costs of preparing responses to this RFI; nor shall the County incur any liability in connection with this RFI.

Responses to this RFI shall not be considered confidential, unless responder clearly labels some portion of the information submitted as "CONFIDENTIAL". All materials provided as part of a response to this RFI shall be considered the property of the County. The County will maintain the right to duplicate and use materials submitted, in whole or in part, for the sole purpose of evaluation, and without identification of agency names.

The County reserves the right to use any, all, or none of the information gathered via this RFI in the preparation of any future solicitation document.

BACKGROUND INFORMATION

Los Angeles County and the HIV/AIDS Epidemic

Spanning more than 4,000 square miles and with nearly ten million residents, Los Angeles County is one of the largest geographic and the most populous County in the nation. Los Angeles County remains the second most HIV/AIDS impacted local health jurisdiction in the United States with approximately 57,000 people living with HIV or AIDS (PLWH/A).

Ryan White Comprehensive AIDS Resources Emergency Act

The Ryan White Comprehensive AIDS Resources Emergency (CARE) Act is Federal legislation that addresses the unmet health needs of PLWH/A by funding primary health care and support services that enhance access to and retention in care. First enacted by Congress in 1990, it was amended and reauthorized in 1995 and again in 2000. In Los Angeles County, the CARE Act funds are managed by the County's Office of AIDS Programs and Policy (OAPP).

Like many health problems, HIV disease disproportionately strikes people in poverty, racial/ethnic populations, and others who are underserved by healthcare and prevention systems. HIV often leads to poverty due to costly healthcare or an inability to work that is often accompanied by a loss of employer-related health insurance. CARE Act-funded programs are the **"payer of last resort."** They fill gaps in care not covered by other resources. Most likely users of CARE Act services include people with no other source of healthcare and those with Medi-Cal/Medicaid or private insurance whose HIV-related care needs are not being met.

CARE Act services are intended to reduce the use of more costly inpatient care, increase access to care for underserved populations, and improve the quality of life for those affected by the epidemic. The CARE Act works toward these goals by funding local and State programs that provide primary medical care and support services; healthcare provider training; and technical assistance to help funded programs address implementation and emerging HIV care issues.

The purpose of **Residential Hospice and Skilled Nursing Facility Services Levels A or B** is to serve as an integral component of Los Angeles County's Removal of Barriers to HIV/AIDS care by augmenting and supplementing Los Angeles County's existing services for HIV-positive clients who require residential and Skilled Nursing Facility Services Levels A or B. The services should be geographically distributed throughout Los Angeles County and be easily accessible by clients and their support givers.

With the introduction of anti-viral therapies, people with HIV are living long and productive lives. The need for skilled nursing or hospice care for people with AIDS who are nearing the end of their lives has greatly diminished. However, since there is no cure for AIDS, some people continue to decline in health over time and are faced with a terminal diagnosis. For some of these people, hospice services can alleviate suffering and provide a more comforting environment for patients and their families and support networks. Skilled nursing may also be required at times of declines in health that do not warrant a hospital stay.

Residential hospice and skilled nursing are Medi-Cal funded services, provided to all eligible beneficiaries. Most, if not all, AIDS patients nearing end of life and needing hospice care are eligible for Medi-Cal, rendering the use of CARE Act funds inappropriate. Given that a few AIDS patients in Los Angeles County will not qualify for Medi-Cal, hospice services and skilled nursing for indigent patients and others without alternative payer sources will still be necessary at some level.

UNITS OF SERVICE TO BE FUNDED

OAPP will fund programs that are geographically dispersed throughout Los Angeles County for Residential Hospice and Skilled Nursing units of service (bed days) for those clients who are not eligible for Medi-Cal or other third party reimbursement, have an HIV/AIDS diagnosis, and who are medically eligible (See "Definitions and Descriptions"). The rate should be an **all-inclusive rate** that includes pharmaceuticals, lab services, and all other services as required for appropriate care as outlined for a "24-hour bed day". OAPP intends to fund 100-150 Residential Hospice units, and 1,000-1,500 Skilled Nursing Facility Service units per twelve-month contract year.

RESIDENTIAL HOSPICE SERVICES

LICENSURE CATEGORY

The State of California requires the facility to be licensed as a Residential Care Facility for the Chronically Ill, Congregate Living Health Facility, or a Skilled Nursing Facility Level A or B with additional requirements of Federal Medicare certification and licensed by the State of California as a Hospice Provider, or to be in a legally binding contractual agreement with an agency certified as a Hospice Provider that provides the hospice services for the facility.

DEFINITIONS AND DESCRIPTIONS

Residential Hospice means a residential facility that provides supportive care, including nursing, pharmacy, dietary, recreational, and other medical and social services.

“Hospice” means a public agency or private organization, or a subdivision thereof, or a facility which:

- is primarily engaged in providing required items and services to terminally ill individuals;
- makes such services available as needed on a 24-hour basis; and
- provides bereavement counseling for the immediate family and significant others.

“Hospice Care” means the provision of services in a humanitarian way for the patient to approach death with dignity, in relative comfort in a supportive atmosphere, and surrounded by family members/significant others. Hospice advocates personal care and concern, living comfortably until death, the absence of pain, maintenance of personal control, and treats the patient, family, and significant other as the unit of care.

“Terminally ill” means that an individual’s medical prognosis, as certified by a licensed physician, is that his or her life expectancy is 6 months or less. To be eligible for residential hospice services, a physician’s certification is required. The physician’s certification must be accompanied by “specific clinical findings and other documentation that support the medical prognosis” and be “filed in the medical record” with the written certification.

PROGRAM REQUIREMENTS

General Requirements: The Residential Hospice Facility must ensure its ability to meet the needs of the client by meeting the general standards as required by the facility’s licensure category and certification.

- ***Intake and Assessment:*** Prior to accepting a client into a Residential Hospice Facility, the person responsible for admissions must interview the prospective client and his/her authorized representative, and the assigned case manager, if any, to complete the following goals and document the intake and assessment findings:
 - ***Eligibility Determination:*** To be eligible for a Residential Hospice Facility, persons must have HIV/AIDS, must be certified by a licensed physician as terminally ill and must have OAPP Medical Director written authorization prior to or within 72 hours of admission, and have income at or below 400% of the Federal Poverty Level. During the six months authorization, should a client no longer meet the criteria of being “terminally ill”, the client should be transitioned to another stable living environment.
 - ***Payer of Last Resort:*** Since Ryan White CARE Act funds must be considered funds of last resort, providers must develop criteria and procedures to determine client eligibility and to ensure that no other options for residential services are available. Providers must document client eligibility, and must further demonstrate that third party reimbursement (e.g., Medi-Cal) is being actively pursued, where applicable. Providers must provide documentation determining client financial eligibility. OAPP will not pay for Medi-Cal pending clients.
 - ***Assessment:*** Includes age, the assessment of health status, including HIV prevention needs, family status, need for palliative care, record of medications

- and prescriptions, ambulatory status, family composition, special housing needs, level of independence/level of resources available to solve problems, and comorbidity factors.
- **Resident Education:** If a prospective client is deemed eligible for intake, the facility staff should provide the client with information about the facility and its services including policies and procedures, confidentiality, safety issues, facility rules and activities, client rights and responsibilities, and grievance procedures.
 - **Advanced Directives:** If a prospective client is deemed eligible for intake, the facility staff should discuss preparation of an Advanced Directive and assist the client in completing one, if desired.
- **Referral Services:** Referrals for services should be made at any point at which the needs of the client cannot be met by the facility within its established programs or services and should be documented as part of the individualized needs and services plan.
 - **Certification**
A licensed physician must provide written certification that the client meets the definitions for eligibility for hospice care; i.e., be considered to be terminally ill due to HIV/AIDS infection, with a life expectancy of up to six months. The certification must clearly indicate that hospice services were required on an inpatient basis because of the individual's need on a daily basis, for skilled nursing or palliative care services. Certifications must be obtained within 72 hours of client admission to the hospice facility and be provided to the OAPP Medical Director for approval. The OAPP Medical Director can make the approval for residence in a hospice facility for up to six months.
 - **Recertification**
If a client is still in need of hospice services following the initial six-month approval, the client must be recertified. The recertification statement must meet the following standards as to its contents: it must contain an adequate written record of the reasons for the continued need for hospice services, the estimated period of time the patient will need to remain in the facility, and any plans, where appropriate, for home care or discharge to another facility. The recertification request will be reviewed by the OAPP Medical Director, and further approval will be granted for up to one month. Clients must be recertified by a licensed physician, with the approval of the OAPP Medical Director, each month following the initial certification approval has expired. A statement reciting only that continued hospice services are medically necessary is not, in and of itself, sufficient.

REQUIRED STAFFING

The Residential Hospice Facility must have staffing in accordance with the facility's licensure requirements.

LENGTH OF STAY

Eligible clients are approved for hospice services for up to six months, as certified by a licensed physician, or until the client no longer meets criteria. Any extensions beyond the six month length of stay require recertification by the physician and authorization by the OAPP Medical Director.

SERVICES

Residential Hospice Facilities should provide the following services:

- Services for persons who have a diagnosis of terminal illness including, but not limited to:
 - residential services,
 - medical supervision,
 - nursing and supportive care,
 - pharmacy services,
 - laundry services, and
 - dietary services.
- Hospice care, including the provision of palliative and supportive items and services described below to a terminally ill individual who has voluntarily elected to receive such care in lieu of curative treatment related to the terminal condition:
 - nursing services;
 - physical or occupational therapy or speech-language pathology;
 - medical social services under the direction of a physician;
 - medical supplies and appliances;
 - drugs and biologicals;
 - physician services;
 - counseling, including bereavement, dietary, and spiritual counseling; and
 - any other item or service for which payment may otherwise be made under the Medi-Cal program.
- For palliative care, the Residential Hospice Facility will provide, within its scope of services offered, timely care and support for each resident so that he/she may live as fully and as comfortably as possible within the context of the resident's values and symptoms. These outcomes are accomplished when:
 - The resident is provided with accurate and timely information to make treatment decisions.
 - The service plan supports the resident's choices that are consistent with the resident's advance directives, values, spiritual preferences, and life-long living patterns, even though these decisions may involve increased risk or personal harm to the resident.

MEDI-CAL COVERAGE

Residential Hospice Facility services are a covered Medi-Cal service, and OAPP will not reimburse for Medi-Cal pending clients, or any other clients who have alternate resources to pay for services.

SKILLED NURSING FACILITY SERVICES

NUMBER OF PROGRAMS AND UNITS OF SERVICE TO BE FUNDED:

OAPP will fund 1,000-1,500 units of service in geographically dispersed programs for provision of Skilled Nursing Facility units of service (24-hour bed days), for those clients who are not eligible for Medi-Cal or other third party reimbursement, and who are medically eligible.

LICENSURE CATEGORY

The State of California requires the facility to be licensed as a Skilled Nursing Facility Level A or B or CLHF in accordance with Medicare and Medi-Cal regulations, and the contractor be licensed to provide Skilled Nursing Facility Services Levels A or B by the California Department of Health Services and in accordance with Medicare and Medi-Cal regulations.

DEFINITIONS AND DESCRIPTIONS

“Daily Skilled Services” means Nursing Facility Services Levels A or B or skilled rehabilitation services (or a combination of these services) must be needed and provided on a “daily basis.” i.e. on essentially a 7-day-a- week basis.

Skilled Nursing Facility Level A or B means an institution or a distinct part of an institution such as a skilled nursing home, congregate living health facility, or rehabilitation center, which has a transfer agreement in effect with one or more participating hospitals and which:

- Is primarily engaged in providing skilled nursing care and related services for residents who require medical or nursing care, or rehabilitation services for the rehabilitation of injured, disabled, or sick persons, and
- Meet the requirements for participation in 1819 of the Social Security Act and in regulation 42 CFR, part 483, subpart B.

For Medicare purposes, the term Skilled Nursing Facility Service does not include any institution that is primarily for the care and treatment of mental disease or tuberculosis.

“Skilled Nursing and/or Skilled Rehabilitative Services” means those services, furnished pursuant to physician’s orders, that

- Require the skills of qualified technical or professional health personnel such as registered nurses, licensed practical (vocational) nurses, physical therapists, occupational therapists, and speech pathologists or audiologists, and
- Must be provided directly by or under the general supervision of these skilled nursing or skilled rehabilitative personnel to assure the safety of the patient and to achieve the medically desired result.

NOTE: “General supervision” requires the initial direction and periodic inspection of the actual activity. However, the supervisor need not always be physically present or on the premises when the assistant is performing services.

PROGRAM REQUIREMENTS

General Requirements: The Skilled Nursing Facility must ensure its ability to meet the needs of the client by meeting the general standards required by the facility's licensure category and certification.

- ***Intake and Assessment:*** Prior to accepting a client into a Skilled Nursing Facility, the person responsible for admissions must interview the prospective client and his/her authorized representative, and the assigned case manager, if any, to complete the following goals and document the intake and assessment findings:
 - ***Eligibility Determination:*** To be eligible for Skilled Nursing Facility Services Levels A or B, OAPP Medical Director's authorization prior to or within 72 hours of admission is required, and the client must have income at or below 400% of the Federal Poverty Level. During the up to one (1) month authorization, if a client should no longer meet the criteria for Skilled Nursing Facility Services Levels A or B, the client should be transitioned to another stable living environment.
 - ***Payer of Last Resort:*** Since Ryan White CARE Act funds must be considered funds of last resort, providers must develop criteria and procedures to determine client eligibility and to ensure that no other options for residential services are available. Providers must document client eligibility, and must further demonstrate that third party reimbursement (e.g., Medi-Cal) is being actively pursued, where applicable. Providers must provide documentation determining client financial eligibility. OAPP will not pay for Medi-Cal pending clients.
 - ***Assessment:*** Includes age, the assessment of health status, including HIV prevention needs, family status, health status, record of medications and prescriptions, ambulatory status, family composition, special housing needs, level of independence/level of resources available to solve problems, and comorbidity factors.
 - ***Resident Education:*** If a prospective client is deemed eligible for intake, the facility staff should provide the client with information about the facility and its services including policies and procedures, confidentiality, safety issues, house rules and activities, client rights and responsibilities, and grievance procedures.
 - ***Advanced Directives:*** If a prospective client is deemed eligible for intake, the facility staff should discuss preparation of an Advanced Directive and assist the client in completing one, if desired.
- ***Referral Services:*** Referrals for services shall be made at any point at which the needs of the patient cannot be met by the facility within its established programs or services and shall be documented as part of the individualized needs and services plan.
- ***Support Services:*** Support services that are to be provided or coordinated must include, but are not limited to:
 - Provision and oversight of personal and supportive services (assistance with activities of daily living and instrumental activities of daily living)

- Health related services (e.g., medication management services);
 - Social services;
 - Dietary services;
 - Recreational activities;
 - Meals;
 - Housekeeping and laundry;
 - Transportation.
- ***Discharge Planning:*** Such services shall include, but not be limited to, a weekly evaluation of each County responsible patient's medical and functional suitability for remaining in Contractor's Skilled Nursing Facility. Based on this ongoing evaluation, if the patient should require relocation to a more appropriate level of care, Contractor shall initiate a referral and assist with such relocation. The County's intent is that Skilled Nursing Facility Services Levels A or B be utilized for persons who require twenty-four (24) hour care and supervision.
 - ***Principles for Determining Whether A Service is Skilled:***
 - If the inherent complexity of a service prescribed for a patient is such that it can be performed safely and/or effectively only by or under the general supervision of skilled nursing or skilled rehabilitation personnel, the service is a skilled service;
 - The nature of the service and the skills required for safe and effective delivery of that service are considered in deciding whether a service is a skilled service. While a patient's particular medical condition is a valid factor in deciding if skilled services are needed, a patient's diagnosis or prognosis should never be the sole factor in deciding that a service is not skilled.
 - ***Certification***

The certification must clearly indicate that Skilled Nursing Facility Services Levels A or B were required on an inpatient basis because of the individual's need on a daily basis, for skilled nursing or rehabilitation services, for either a condition for which he/she received inpatient hospital services prior to the transfer to the facility, or for a condition, which arose after transfer to the facility, or for a condition which arose after transfer while he/she was still in the facility for treatment of a condition for which he/she received inpatient hospital services. Certifications must be obtained within 72 hours of admission. Certifications must be completed by a licensed physician and approved by the OAPP Medical Director. Initial certifications will be granted for a period of up to one month. Clients needing Skilled Nursing Facility Services Level A or B following the expiration of the initial approval of certification must be recertified bi-weekly.
 - ***Recertification***

The recertification statement must meet the following standards as to its contents: it must contain an adequate written record of the reasons for the continued need for extended care services, the estimated period of time the patient will need to remain in the facility, and any plans, where appropriate, for home care. The recertification statement made by the physician has to meet the content standards, unless, for

example all of the physician's statement could indicate that the individual medical record contains the required information and that continued Skilled Nursing Facility Services Levels A or B are medically necessary. A statement reciting only that continued extended Skilled Nursing Facility Services Levels A or B are medically necessary is not, in and of itself, sufficient. The recertification must be submitted to and approved by the OAPP Medical Director.

REQUIRED STAFFING

The Skilled Nursing Facility must have staff qualified to manage the facility and provide patient care in accordance with requirements set forth in the agency's licensure category and certification.

LENGTH OF STAY

Length of stay is up to thirty (30) days as certified by a licensed physician and preapproved by OAPP Medical Director. Any extensions beyond the thirty (30) day length of stay requires bi-weekly recertification by the physician and authorization by OAPP Medical Director.

MEDI-CAL COVERAGE

Skilled Nursing Facility Services Levels A or B are covered Medi-Cal services, and OAPP will not reimburse for Medi-Cal pending clients, or any other clients who have alternate resources to pay for services.

ADDITIONAL ACTIVITIES

Providers in both categories will be expected to provide or conduct the following activities as part of their proposed all inclusive, comprehensive rates:

- **Promotion and Outreach** - Providers must promote and educate clients, HIV/AIDS service providers and the Service Planning Area (SPA) based Community Services Assessment Centers regarding the availability of these services, in order to promote awareness of and access to services to residents throughout the County.
- **Culturally and Linguistically Appropriate Services** – Services must be culturally and linguistically appropriate for the target population(s). Providers must describe how they will use other services to limit language and cultural barriers. Program staff must display nonjudgmental, culture-affirming attitudes. Program staff should affirm that clients of ethnic and cultural communities are accepted and valued. Programs are urged to participate in an annual self-assessment of their cultural proficiency.
- **Community Needs and Provider Expertise** – Providers must design a model of residential services that addresses and is reflective of the community being served.
- **Payer of Last Resort** – Since Ryan White CARE Act funds must be considered funds of last resort, providers must develop criteria and procedures to determine

client eligibility and to ensure that no other options for residential services are available. Providers must document client eligibility, and must further demonstrate that third party reimbursement (e.g., Medi-Cal) is being actively pursued, where applicable. Providers must provide documentation determining client financial eligibility and subsequent changes to eligibility. OAPP will not pay for Medi-Cal pending clients.

- **Referrals** – Providers are expected to note and track referrals to and from organizations using OAPP’s Casewatch data system, provided by OAPP.

When necessary, Providers will be expected to make “linked referrals” for clients. “Linked referrals” are not only meant to show that the client has been referred for other services, but they require that the provider takes the steps necessary to ensure that the client has accessed those services once referred.

Providers must be able to demonstrate that there are mechanisms in place to ensure that eligible clients from other service delivery systems can access these CARE Act-funded services. This may include, but is not limited to mental health, primary health care and social services organizations. OAPP will work with providers to determine how best to document and demonstrate that those mechanisms are adequately implemented.

Providers will be required to use OAPP’s service utilization data management system (CaseWatch) to help facilitate, connect and access referrals from providers to one another, and services to one another—and for other system innovations. One of those efforts, HIV/AIDS Interface Technology Systems (HITS), is scheduled to launch within this year. Linking the counseling/testing and medical outpatient environments via data management, HITS will expedite and ease the entry of newly diagnosed HIV+ individuals into the system of care through an automatic referral and reporting system.

- **Participation in Service Provider Networks** – There are currently SPNs in all of Los Angeles County’s eight SPAs. The SPN is an essential ingredient in an equation to develop more localized, regional planning and service efforts that can better and more effectively respond to clients’ needs. However, the SPN concept needs active provider involvement for successful operations and planning. Consequently, starting this year, active provider participation in their respective SPNs is expected of every CARE service organization. Active communication and promotion of services with the SPN is expected and required.
- **Quality Management Plans** – Providers are expected to develop and implement an annual Quality Management Plan that addresses the following components: QM Committee, Written Policies and Procedures, Client Feedback, Program Staff, Measurable Program/Service Quality Indicators, QM Plan Implementation, and Quality Assessment and Management Reports. The QM Plan must include a mechanism for client feedback. The QM Committee shall consist of persons

representative of the program and agency such as clients, volunteers, program staff, management, consultants and others (e.g., staff from other community-based organizations).

Unit(s) of Service

The unit of service that providers must use to track services is the number of unduplicated clients and the number of service days delivered. A “Resident Day” unit of service is defined as a twenty-four (24) hour period in which a resident receives housing and meals. Furthermore, for residential services, the number of units of service billable will be the number of days an individual occupied a bed (physically present in the facility overnight), including either the first day of admission or the day of discharge, but not both, unless entry and exit dates are the same.

Bed-Hold Policy

OAPP will permit contracted agencies to hold a client’s bed in medical emergencies or for therapeutic reasons, as long as this is clearly documented in the client’s chart and/or treatment plan. OAPP will reimburse for no more than two (2) one-night ‘bed-holds’ per client per quarter under the following circumstances: (a) ‘Bed-holds’ cannot be carried over from one quarter for use in a future quarter; (b) OAPP cannot reimburse for a ‘bed-hold’ if the client does not return and continue to stay at the agency after the ‘bed-hold’ occurs.

Client Eligibility

(Determined through standard eligibility screening)

To determine if a client is eligible to receive Residential Services funded through OAPP, service providers will be expected to complete standardized financial and insurance screening as well as verify HIV diagnosis and Los Angeles County residency. For clients with income over 400% of poverty, a sliding fee scale can be imposed.

OFFICE OF AIDS PROGRAMS AND POLICY

**REQUEST FOR INFORMATION: RESIDENTIAL HOSPICE AND
SKILLED NURSING FACILITY SERVICES LEVEL A OR LEVEL B**

Please answer each question as it pertains to the services your agency would or could provide. Please indicate which services by marking all appropriate and answer questions by entering text in the gray boxes.

☐ **Residential Hospice Facility Services**

☐ **Nursing Facility Services Level A**

☐ **Nursing Facility Services Level B**

1. **What is the name of your agency?**
2. **Where are facilities located (please include complete address with zip codes)?**
3. **What type of licensure or certification does your agency currently have and for how many beds in each category?**

a. Congregate Living Health Facility (CLHF)	_____	beds
b. Residential Care for the Chronically Ill (RCFCI)	_____	beds
c. Nursing Facility Level A	_____	beds
d. Nursing Facility Level B	_____	beds
e. Other Skilled Nursing Facility	_____	beds
f. Hospice Certification	_____	beds
g. Other:	_____	beds
4. **How many years has the facility been in operation?**
5. **a. Has the facility provided care for HIV/AIDS patients?** ☐ Yes ☐ No
b. If YES, for how long?
6. **How many clients/residents do you currently serve? Provide a total count of clients by service site, and give the percentage of HIV/AIDS patients at each site (range over the past twelve months).**
7. **Does the facility have experience providing hospice services?**

8. What are the Skilled Nursing needs of the HIV/AIDS patients being seen in your facility (general levels of acuity)?
☐ High Acuity ☐ Medium Acuity ☐ Low Acuity
9. What is the average length of stay for HIV/AIDS patients (average and range) for hospice?
10. What is the average length of stay for HIV/AIDS patients (average and range) for nursing facility services?
11. Does your agency have an Infectious Disease Physician or HIV Specialist Physician on Staff or available through a consulting arrangement?
12. What are the sources of referrals to your agency for HIV/AIDS patients?
13. How does your agency link HIV/AIDS patients to other support services?
14. Does your agency have an Electronic Medical Record or other data collection system?
15. a. Is your organization certified to provide Medi-Cal services? ☐ Yes ☐ No
b. Medicare? ☐ Yes ☐ No
c. Does your organization bill other third-party insurers? ☐ Yes ☐ No
d. If yes, please specify:
16. Does your agency currently meet or exceed staffing plans as required by licensure category and services provided? Please explain.
17. a. Does your organization use standards and/or practice guidelines to set performance and quality parameters? ☐ Yes ☐ No
b. If yes, please indicate which standards/guidelines you use.
18. a. Does your organization have a client/resident/family education program?
☐ Yes ☐ No
b. If yes, please describe how this works.
19. Does your organization conduct a client satisfaction survey or interviews?
☐ Yes ☐ No

20. Are there any specific regulatory or financing barriers your organization faces in the delivery of services to persons with HIV disease or AIDS?
21. Is there anything else you would like to discuss about your organization pertaining to the rate setting or regulatory process? Use additional sheets if necessary.
22. Please provide an estimate of the all-inclusive cost to your agency of providing one bed-day of service for a hospice patient (if your agency may provide these services).
23. Please provide an estimate of the all-inclusive cost to your agency of providing one bed-day of service for a nursing facility services patient (if your agency may provide these services).

Please provide your contact information below.

Name and Title

Agency

Agency Address

Telephone

Fax

Email

THANK YOU FOR COMPLETING THIS SURVEY. PLEASE SEND THE COMPLETED SURVEY BY THURSDAY, MAY 26, 2005, IN THE ENCLOSED ENVELOPE, BY FAX, OR BY EMAIL TO:

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Division of Planning and Research
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Los Angeles, CA 90005
Phone: (213) 351-8048
Fax: (213) 381-8023
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